

FLEXIBLE SPENDING ACCOUNT

Election Form and Pay Reduction Agreement

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District of Columbia Government

Employee Information			
Employee Name:	Social Security Number:	Agency Name:	
Current Home Address (including city, state & zip code):		Home Phone (including area code):	
		Work Phone (including area code):	
Plan Year Begins: January 1, 2006	Plan Year Ends: December 31, 2006	Grace Period to file claims: 90 days after plan year ends	Date of Hire:
Status Change Events			
<p>You may not change your FSA election during the plan year unless you have a change in status event. An exception is made when the status event is a change in legal marital status or employment status. Change in legal marital status: Events that change employee's legal marital status, including the following: marriage, death of a spouse, divorce, legal separation, and annulment; Number of Dependents: Events that change an employee's number of dependents including the following: birth, death, adoption, and placement for adoption. A dependent is formally defined to be a tax dependent under Code Section 152. This rule would not allow election changes for non-tax dependents such as parents, domestic partners, and children of domestic partners; Dependent Satisfies or Ceases to Satisfy Eligibility Requirements: Events that cause an employee's dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status or any similar circumstance; Employment Status: Any of the following events that change the employment status of the employee, the employee's spouse or the employee's dependent: a termination or commencement of employment, a strike or lockout, a commencement of or return from unpaid leave of absence; and a change in worksite. Also included is if an employee switches from salaried to hourly-paid with the consequence that the employee ceases to be eligible for the plan; Residence: A change in the place of residence of an employee, spouse or dependent; Adoption Assistance: For purposes of adoption assistance through a cafeteria plan, the commencement or termination of an adoption proceeding; Other Allowed Change Events: Change in day care provider, Change in cost of day care provider (does not apply when day care provider is a relative); judgment, decree or order requiring change in coverage; entitlement to or loss of Medicare or Medicaid coverage; special requirements relating to Family and Medical Leave Act (FMLA); COBRA election under employee's plan; HIPAA Special Enrollment Rights. Direct Deposit Note: Please check with your financial institution before drawing funds. The funds will generally be available 4 business days after the check date. FlexAmerica and the District of Columbia Government are not responsible for overdraft charges.</p>			
Flexible Spending Account Elections			
Account(s)		Annual Election	
<input type="checkbox"/> Healthcare (\$3,000 Maximum; \$100 Minimum)		\$	
<input type="checkbox"/> Dependent (\$5,000 Maximum; \$100 Minimum)		\$	
Waiver of Participation			
<input type="checkbox"/> I acknowledge I have been informed of the terms of the flexible spending account options. Even though I am eligible to participate in the plan, I hereby elect not to enroll for this plan year; however, I may enroll this plan year if I have a change in status.			
Participation Agreement & Salary Reduction Authorization			
<p>As an eligible employee, I acknowledge that I have received and read the Summary Plan Description and that I understand the benefits, rights, and obligations available to me under the plan and that the above deductions, if any, will be made on a pre-tax basis.</p>			
<input type="checkbox"/> My spouse is an employee of the District of Columbia Government and is eligible to join Flexible Spending Account Program.			
_____ Employee Signature		_____ Date	
		Dependent Care Participants: <input type="checkbox"/> I earned over \$100,000 in the prior plan year before any deductions.	
OCB USE ONLY:			
Date Deductions Will Start:	Eligibility:	# of Pay Periods remaining this Plan Year:	Per Pay Period Amount (Payroll Entry)
			Healthcare Account \$
			Dependent Care Account \$

THIS FORM MUST BE RETURNED TO YOUR DESIGNATED HUMAN RESOURCES OFFICE BY DECEMBER 12, 2005 (NO EXCEPTIONS). PLEASE SEE THE ENCLOSED CONTACT LIST.